

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008562
STATE FILE NUMBER

FILED APR 6 1959
XC-18096687
REG.#A451

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 141

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY DUNKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		c. CITY OR TOWN KENNETT	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL 6 DAYS		d. STREET ADDRESS (If outside, give location) 916 PRUITT STREET	
3. NAME OF DECEASED (Type or print) First DANIEL Middle (NONE) Last LAWSON		4. DATE OF DEATH Month MARCH Day 23 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-20-93
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) DUNKLIN COUNTY, MISSOURI
13a. FATHER'S NAME JOHN LAWSON		13b. MOTHER'S MAIDEN NAME LEE SPARKS	14. NAME OF HUSBAND OR WIFE ELSIE LAWSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 488420856	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE #1. INFARCTION OF MYOCARDIUM DUE TO ARTERIOSCLEROTIC CORONARY THROMBOSIS. #2. UREMIA, DUE TO DIAGNOSIS #1. #3. ACIDOSIS, DUE TO DIAGNOSIS #1. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1. BENIGN PROSTATIC HYPERTROPHY. 2. INTERNAL & EXTERNAL HEMORRHOIDS.			INTERVAL BETWEEN ONSET AND DEATH 48 Hours 48 Hours 48 Hours
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORKING <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from March 17, 1959 to March 23, 1959 and last saw her alive on March 23, 1959 at 7:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. W. GASKINS, M.D., Chief, Surgical Svc.		22b. ADDRESS VA Hospital, Poplar Bluff, Mo.	
22c. DATE SIGNED 3/24/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-25-59	23c. NAME OF CEMETERY OR CREMATORY Oak Ridge Cemetery	23d. LOCATION (City, town, or county) (State) Kennett Mo.
24. FUNERAL DIRECTOR Lentz Service		25. DATE REC'D. BY LOCAL REG. 3/28/59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER- --

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4433

P. O. Address Kennett Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.